Closed-Loop Referrals for Health-Related Social Needs: Barriers and Recommendations

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EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

Introduction

Health-related social needs (HRSNs) significantly impact the ability to achieve equitable access to care and optimal health outcomes. Recognizing this, healthcare organizations and policymakers are increasingly seeking opportunities to address social drivers of health (SDOH) within care models – particularly through closed-loop referrals.

A closed-loop referral system for HRSNs would track the referral from the originating healthcare provider to the social service organization and back, confirming that services have been received, and ensuring that the patient's social needs are met and documented. While similar in the abstract, referrals to social care organizations involve complexities far beyond those encountered in typical healthcare referrals among healthcare providers.

The HIMSS Electronic Health Record (EHR) Association's SDOH and Health Equity Workgroup explores the significant barriers to implementing closed-loop referrals for health-related social needs. While initiatives like the 360X Closed Loop Referral Implementation Guide and USCDI v4 are valuable, they represent just the initial steps in a long journey. Much more is needed to address non-technical barriers to realize the vision of closed-loop HRSN referrals.

Recognizing the necessity for flexible standards, financial incentives, and tailored local approaches, we share the following insights and recommendations for policymakers and influencers to enhance equitable access to care and optimize health outcomes.

Barriers to Implementing Closed-Loop Referrals for HRSNs

Variability in local resources and needs hinders the effectiveness of closed-loop referrals.

Technological disparities among organizations complicate seamless data exchange and effective patient referrals.

Complex and varied referrals require sophisticated data systems.

Ineffective feedback mechanisms overwhelm providers with unnecessary information or fail to provide necessary updates.

Limited readiness for standardization due to varying adoption and differing capabilities among health systems.

Localized Needs and Resource Availability

Historically, the United States has long relied on community-based organizations (CBOs) to address social needs. With deep roots in the community and constrained geographical focus, CBOs are well-positioned to provide hyperlocal services that are uniquely tailored to a community's needs, yet this also means that addressing HRSNs effectively requires an intimate understanding of local community resources and needs. Each community is unique, with specific social challenges and available support services, which makes standardization difficult.

For example, urban areas might have numerous social service providers, whereas resources in rural areas may be limited. Service availability can also fluctuate based on state-level funding and policies, particularly under Medicaid. CBOs may overlap in the types of services they provide, or differ in which clients they serve or how they accept clients, and their capacity for new clients may also vary greatly.

The variability in local resources and needs means that a one-size-fits-all approach is impractical. Effective closed-loop referrals must be tailored to the specific context of each community, which requires robust, localized directories and a deep understanding of community assets.

Technological Disparities Among Organizations

The landscape of organizations addressing HRSNs is highly varied, with significant differences in technological capabilities. While some CBOs operate advanced technology platforms capable of seamless data exchange, others rely on paper-based systems. The variation in CBO funding means that some organizations can easily support 24/7 connectivity while others may not even be able to answer the phone consistently.

This disparity poses a fundamental challenge: the assumption that all organizations can conform to a unified standard is unrealistic. Effective patient referrals must navigate these technological gaps, which can vary dramatically across different local contexts.

For instance, a food pantry might operate on a basic, manual system, making integration with EHRs difficult. Conversely, a large social service organization might have the infrastructure to handle sophisticated digital referrals but is unable to communicate with less technologically advanced partners. This fragmentation requires flexible expectations that can adapt to various levels of technological readiness.

Complexity and Variety of Referrals

HRSN referrals are inherently complex and diverse. Unlike medical referrals, which typically involve a single instance of care, HRSN referrals can range from short-term assistance, such as food vouchers, to long-term programs, such as job training. The nature of these referrals varies significantly based on the needs of the individual.

For example, a referral for emergency housing might involve multiple touchpoints and require ongoing support, whereas a referral for a one-time utility payment may be resolved quickly. The ability to track and manage these varied referrals necessitates a sophisticated data language that can represent different types of needs, interventions, durations, and outcomes.

Challenges of Feedback Mechanisms

Closed-loop referrals rely on feedback mechanisms that inform referring providers about the status of the referral. However, this feedback is not always necessary or feasible. Providers often express that receiving status updates on every referral can be overwhelming and counterproductive. An emergency room provider who refers the patient to a CBO is unlikely to have a long-term relationship with that patient that would benefit from regular updates, but if that emergency room is part of an accountable care organization, pooling data about referrals and outcomes is highly important.

Multiple approaches might be needed to accommodate these varied use cases. For example, some use cases might benefit from a system where a provider can check in on the fulfillment of the referral without being inundated with unnecessary information. This balance requires thoughtful design of feedback systems to ensure they are informative without being burdensome.

Readiness for Standardization

Communicating the identified need, requested resources, and the status of the request requires shared standards. While USCDI v4 introduces many of the communications standards for SDOH, its implementation will take considerable time as EHRs are currently moving toward the required adoption of USCDI v3 (January 2026).

While essential, the push towards standardization – exemplified by the USCDI v4 – is insufficient on its own. While EHRs are making strides towards adopting these standards, many health systems are not yet ready to fully integrate the social care components required for HRSNs. The healthcare delivery system is still evolving in its ability to formally represent and manage social needs.

A hybrid approach employing both traditional and innovative methods is necessary to bridge the gap between current capabilities and future requirements. This includes supporting standards for closed-loop referrals and accommodating the existing variability in readiness and infrastructure among social care organizations.

Grant and Funding Opportunities

Medicaid funding, including utilization of Medicaid 1115 waivers that offer opportunities for SDOH reimbursement, varies significantly across states. This leads to a lack of uniformity in funding and support for HRSN initiatives, creates challenges for standardization, and complicates efforts to develop a consistent approach to closed-loop referrals. Policymakers must recognize and address these disparities to create a more cohesive framework for funding and support.

Incentivizing the development of closed-loop referral systems through grants and funding is crucial. Similar to the Certified Community Behavioral Health Clinic (CCBHC) grants in the behavioral health sector, specific grants for developing HRSN referral capabilities could accelerate progress. These funds would enable CBOs to invest in the necessary technology, infrastructure, and people skills to participate in closed-loop referral systems.

Recommendations

- **Support Flexibility**: Encourage the development and adoption of flexible standards without mandating a one-size-fits-all approach that overestimates CBO readiness.
- **Invest in Third-Party Conveners:** Fund and support third-party directory services to help coordinate and identify local resources effectively.
- **Provide Grants and Incentives**: Establish grants or stipends for CBOs to develop closed-loop referral capabilities, similar to the CCBHC model.
- **Encourage State-Level Innovation:** Promote state-level initiatives to utilize Medicaid 1115 waivers to expand funding for SDOH interventions.
- **Balance Feedback Mechanisms**: Develop balanced feedback mechanisms that accommodate more transient patient-provider relationships or introduce additional stakeholders outside of the original referral pathway.

The Path Forward: Overcoming Barriers and Implementing Recommendations

While initiatives like USCDI V4 and the 360X Closed Loop Referral Implementation Guide are important, more is needed to address the complexities of closed-loop referrals for HRSNs. Flexibility, local context, and a hybrid approach accommodating varying technological capabilities are essential, and it is imperative that the standards not outpace the reality.

Policymakers must recognize these barriers and support funding mechanisms to enable the development of robust closed-loop referral systems that can truly address health-related social needs.

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